DOCUMENT RESUME

ED 376 248 UD 030 158

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TITLE Cross-Cultural Concepts Training for Medical Students and Acculturation Training for Residents.
PUB DATE Apr 94
NOTE 14p.; Paper presented at the Annual Meeting of the American Educational Research Association (New Orleans, LA, April 4-8, 1994).
PUB TYPE Reports - Descriptive (141) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Acculturation; Adjustment (to Environment); Attribution Theory; *Cross Cultural Studies; *Cultural Awareness; Cultural Pluralism; English (Second Language); Higher Education; *Immigrants; *Medical Students; *Physicians; Social Behavior; Socialization; Training
IDENTIFIERS *Culture Assimilator

ABSTRACT

An approach to increasing the knowledge of and skills in intercultural interactions for medical students and residents is described. For medical students, a lecture on cross-cultural concepts for health care is incorporated into the second-year psychiatry and behavioral medicine course. For residents, in this case international medical school graduates, a four-faceted approach includes training in clinical skills, intercultural attributions, English as a Second Language, and social skills and socialization. Each component is designed to address key areas that influence residents' clinical and social skills and their adjustment to American culture in general and to the clinical environment in particular. Intercultural training with a culture assimilator (a collection of materials to prepare a member of a given culture to make attributions that enhance interaction) can be culture specific or culture general. The attribution training approach selected for resident physicians is culture general because of the frequency and unpredictability of the intercultural interactions that occur in clinical settings. Contains 12 references. (Author/SLD).

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ED376248

"Cross-Cultural Concepts Training for Medical Students and Acculturation Training for Residents"

Cultural Diversity Education in the Professions

(Session 26.48)

Division I, E & K Symposium/Table

April 6, 1994

American Educational Research Association

New Orleans

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Cross-Cultural Concepts Training for Medical Students

and

Acculturation Training for Residents

Abstract

An approach to increasing medical students and residents knowledge and skills in intercultural interactions are reported in this paper. For medical students, a lecture on cross-cultural concepts for healthcare is incorporated into the second-year psychiatry and behavioral medicine course.

For residents, a four-faceted approach includes training in clinical skills, intercultural attributions, English as a Second Language, and social skills/socialization. Each component is designed to address key areas that influence residents' clinical and social skills and their adjustment to American culture in general, and to the clinical environment in particular.

Intercultural training using the culture assimilator can be culture-specific or culture-general; both are designed to increase trainees' ability to make culturally appropriate interpretations of intercultural situations and behaviors. The attribution training approach selected for resident physicians is culture-general because of the frequency and unpredictability of the intercultural interactions that occur in clinical settings.

Cross-Cultural Concepts Training for Medical Students

The University of Illinois College of Medicine is the largest medical school in the nation, with 300 entering freshman each year. The College has a longstanding commitment to cultural diversity and through its Urban Health Program, admits a minimum of 75 minority candidates each year. Students train at four locations in Illinois: Chicago, Urbana, Rockford, and Peoria. The Peoria site trains 50 of the 300 for the sophomore through senior years. Peoria also educates about 130 residents in one of its 10 fully-accredited programs.

For medical students at Peoria, a lecture on cross-cultural concepts for healthcare was incorporated into the second-year psychiatry and behavioral medicine course. The lecture, entitled "Cross-Cultural Aspects of Psychiatry and Behavioral Medicine" teaches them some key concepts that pertain to healthcare situations that generalize across a number of cultures. These include **acculturation** and the changes that accompany acculturation; culture **etics** and **emics** and why mental or physical illnesses have culture-general and culture-specific features; and reasons for and consequences of misdiagnoses that are due to cross-cultural differences.

As part of the lecture, medical students are also encouraged to analyze their own past cross-cultural difficulties, by responding to the script eliciting a critical incident.

Students are held accountable for the lecture because the final examination in the Psychiatry and Behavioral Medicine Course contains test items that are based on the lecture.

Acculturation Training Model for Residents

A four-faceted training program has been designed for international medical school graduates (IMGs), accepted into one of 10 residency training programs at the University of Illinois College of Medicine at Peoria. Each of residency programs are competitive, are fully accredited by the ACGME, and attract quality residents nationwide. The programs are:

Emergency Medicine

Family Practice

Internal Medicine

Combined Medicine-Pediatrics

Neurological Surgery

Neurology

Obstetrics & Gynecology

Pediatrics

Radiology

Surgery

The acculturation training model described on the next page was developed during the 1993 - 94 academic year. It was reviewed by the University of Illinois College of Medicine at Peoria Joint Committee for Graduate Medical Education, which oversees all of the graduate programs. Its implementation will start with the July 1, 1994 cohort of IMG residents and will be required.

The main components of this program are: clinical skills training, ESL training, attribution training, and social support/socialization. Each component is designed to address key areas that influence residents' clinical and

social skills and their adjustment to American culture in general, and to the clinical environment in particular.

Clinical skills training will strengthen areas in which University of Illinois residency program directors have identified IMGs to typically have weaknesses. Standardized patients will be used to teach physical exam skills for the ear, eye, and pelvic exam. History-taking and problem-oriented recording skills (i.e. the SOAP format) will also be improved.

For those whose oral or written English language skills are weak, special ESL training will be provided on-site, using faculty resources from Illinois Central College and Bradley University.

All IMG's will participate in attribution training, utilizing the critical incident approach. This portion of training will use movies, vignettes, and written material. It will commence with orientation, with monthly sessions throughout the year. The rationale for this approach to acculturation training is explained in detail in the following pages.

Social skills training and opportunities for social support, which on occasion, would include spouses, will be promoted through a variety of regular social events. In addition, each new IMG will be assigned to a mentor, sometimes a senior resident but usually a practicing physician, with whom they will have regular contact.

Attribution Training and Intercultural Interactions

Attribution training has been used to improve intercultural attitudes and interactions. It is sometimes referred to as the culture assimilator or culture sensitizer approach. The term "subjective culture" refers to people's

attitudes, values, and norms of behavior, while objective culture refers to the concrete and visible products that people in a certain culture make, e.g., artifacts, clothes, or books (Triandis, 1972). Because objective culture (e.g., food preferences) is tangible, people more readily recognize that such conflicts relate to cultural differences. When problems stem from differences in subjective culture however (e.g., values), they are often more difficult to recognize.

Attribution training is designed to teach trainees to do just this, to recognize misunderstandings involving subjective culture. This involves developing the ability to make interpretations of situations that are the same as, or "isomorphic" to, a culturally different other's (Triandis, 1977). Making isomorphic attributions will enable one to have culturally appropriate cognitive, affective, and behavioral responses to culturally embedded practices. Consider the following vignette:

> Dr. Saleh Habib from Cairo has been in a residency program in Pennsylvania for the past year. One morning, as he is passing the hospital information desk, he hears his name called. He turns to find one of his close friends, who was one year his junior in medical school in Egypt, and who is now visiting the hospital for a residency interview. His friend embraces and kisses him on both cheeks, saying "Salam!" Dr. Habib returns the greeting but does not hug or kiss his friend. After an awkward moment, he makes an excuse that he has a "very sick patient to see" and leaves.

After only a year in the U.S., Dr. Habib has begun to assimilate American behaviors and norms and finds himself feelings self-conscious about behaviors that were once natural and normal aspect of everyday life. To feel comfortable in this or any other situation that feels awkward because of cultural differences involves learning the criterial attributes culturally different others use to categorize the domains of self, others, objects, and behavior (Triandis, Vassiliou, Vassiliou, Tanaka, & Shanmugam, 1972).

Clearly there are culture-specific elements to this particular incident, and the first culture assimilators were culture-specific. They prepared a member of a given culture to make the type of isomorphic attributions that enhance interactions with members of another given culture (Fiedler, Mitchell, & Triandis, 1971). Those who were preparing for sojourns abroad, foreign diplomats, business people, missionaries, and international medical graduates, among other groups of people, studied these materials. They typically contained short vignettes like the incident above, called "critical incidents," each one depicting a problematic interaction in which cultural differences are brought into sharp relief. Usually the cause of the problem is due to differences in the subjective rather than objective culture of the two groups. Four or five possible alternative explanations for the problem are presented in multiple choice format from which readers may select after they have read the critical incident.

Because there are countless country-pairs, the number of culture assimilators that could be developed are innumerable. This makes them impractical as their development is expensive and time consuming. Another limitation to culture-specific training is that it is not always possible to know in advance

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the cultural groups with which people will interact. Military personnel travel through many countries, as do international consultants on trouble-shooting assignments. Physicians themselves are a diverse group and have to treat patients belonging to many different ethnic groups, without traveling to foreign countries at all. As for residency programs, the ethnic and cultural composition of each new group of incoming residents changes every training year.

The need to prepare these types of individuals prompted Brislin, Cushner, Cherrie and Yong (1986) to develop a culture-general assimilator. Like culture-specific assimilators, the culture-general assimilator uses critical incidents to illustrate reasons for cultural misunderstanding and conflict. It is designed to prepare individuals for intercultural interactions regardless of where they will occur, what a person's role in the other culture will be, and what cultural groups will interact (see Brislin, 1986, for a more detailed discussion). This collection of 100 critical incidents centers around 18 basic themes that cover a broad range of misunderstandings that can occur in intercultural interactions. Although future research will undoubtedly refine these 18 themes, they nonetheless provide a workable framework which individuals can use in understanding intercultural issues, both culture-general and culture-specific.

Empirical Research With Culture-General Assimilator Material

Research conducted by Broaddus (1986), Cushner (1987, 1989), and Ilola (1989, 1991), using treatment-control, pretest-posttest comparison designs, have demonstrated that the culture-general assimilator technique is an effective approach to intercultural training.

Broaddus' sample (undergraduates in a social psychology class) studied nine critical incidents during seven one-hour-and-twenty-minute training sessions. When tested with posttest critical incidents, the treatment group performed significantly better than did non-treatment group members on the mean number of "best choices" (in multiple choice format). Slightly higher but non-significant scores were found for sophistication of analysis of a presented critical incident; ability to distinguish among the terms culture, race, and class; and, ability to generate and analyze a personal critical incident of intercultural misunderstanding. He found a significantly higher posttest score on the Empathy factor, one of five subscales on the Inventory of Cross-Cultural Sensitivity, but this finding was tentative because there were so few responses from the control group.

An international group of adolescent foreign exchange students spending a year in New Zealand were trained with an adapted version of the culture-general assimilator in Cushner's study. They engaged in four one and one-half hour sessions, covering 19 critical incidents. Trained students performed significantly better on four of six measures selected to reflect sophistication of thinking about cross-cultural interaction, interpersonal problem solving strategies, and adjustment to the host culture. When they were tested with posttest critical incidents immediately after training, they selected signifi-

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cantly more of the best answers (a multiple choice task). They also wrote and analyzed a personal critical incident significantly better than did members of the control group. Three months afterwards they scored significantly higher on feelings of personal control of their environment and on one of four subscales on the Culture Shock Adjustment Inventory (Juffer, 1982). Six months later they scored significantly higher on a measure of interpersonal problem solving skills that are related to social flexibility and adjustment, the Means-End Problem Solving Test. No differences were found on self- and significant others' (e.g., host parents) ratings toward objective and subjective aspects of adjustment, or on the total or subscale scores of the Inventory of Cross-Cultural Sensitivity. To summarize, Cushner found training to be particularly beneficial in developing students' cognitive and interpersonal intercultural problem-solving abilities.

In training preservice teachers in Hawaii, Ilola (1989) combined a cooperative learning approach with critical incidents drawn from the culture-general assimilator developed by Brislin et al. (1986). As a function of training, participants showed greater intercultural problem solving ability as demonstrated by solving new problems, providing explanations for underlying issues in intercultural conflict, and analyzing personal experiences. These findings were successfully replicated by training the control group later on. Retention of ability to problem solve, and to a lesser degree, ability to analyze new problems using terms and concepts taught during training was also demonstrated. Moreover, participants reported that they benefited from and enjoyed the training.

Validation of Acculturation Training for Resident Physicians

Although a model has been developed for resident physicians, it has yet to be empirically tested. There is enough research to support extending a culture-general approach to a specific population such as IMG residents. To validate the utility of this component of the proposed training model, vignettes that depict clinical encounters have been written, utilizing the method developed by Brislin et al. (1986). Preliminary validation data are anticipated by July 1994 and program evaluation data, by August 1995.

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